

## Change Leadership In Action

The theme of the closing session at the Ontario Hospital Association Convention and Exhibition was timely indeed: **Change...meeting the challenge**. As the OHA Chair Ellen Sills pointed out, "one of the many challenges before us is ... to instill a positive and accepting attitude for the opportunities made available through change in the hospitals we serve and in the communities in which we live."

With 35 years of experience as an Industrial Psychologist, consultant, facilitator and trainer, Dr. Gerald Pulvermacher is nationally renowned. Indeed, *Maclean's* has characterized him as a "management consultant guru".

For this issue of **Healthcare Horizons**, Dr. Pulvermacher elaborates on the views he shared at this conference.

Change is **first and foremost, change is about people, particularly when the change is large-scale and discontinuous.**

Process re-engineering, information technology transformation, radical downsizing, continuous improvement, mergers, software implementation -- or all the above -- will only work if the very real concerns, needs and aspirations of people are addressed.

Change in the healthcare sector is most often dramatic and abrupt. And only by leading that change, not merely managing it, can senior management expect to achieve organizational goals. The effectiveness of any organizational change enterprise is almost directly linked to effective leadership -- leadership which is aware of and sensitive to the human dimension of change.

### **Resistance is inevitable!**

To effect change successfully within your organization, management must be prepared to anticipate and appreciate resistance to change.

When organizations are confronted by serious and daunting challenges to their viability, leaders tend to look forward for solutions. They come to understand that band aid solutions and quick fixes just won't work any more. They are able to confront the prospect of a major organizational transformation, because they know that only such an action will provide the significant changes required to establish a more effective organization. Senior managers may indeed look forward to the opportunities associated with the major change initiatives.

Individual dynamics in response to organizational change, however, are quite different, and entirely out of sync with the focus of management. Indeed, even if people are aware of the change imperative, many resist. In fact, most resist. According to the literature on enterprise-wide transformation, approximately 30% of people spontaneously resist change, while another 50% will sit on the fence. What this could mean to your organization is that your executives and senior managers must work diligently to encourage 80% of your people both to embrace and champion the change effort. Leading a successful change initiative means leading from the top of the organization as well as all the way through the organization.

### **Why people resist change**

Why do so many people resist change in organizations? In scientific terms, resistance is a force that slows or stops movement. Within people, resistance is a much more complex phenomenon. For the most part, people resist change to protect themselves from perceived threat, whether real or imagined.

The "maps" that people have of themselves include who they work with, where they fit into the power structure of their organization, and comfort in the established skills they have to do their jobs. When these factors and more face the prospect of change, people have to make a major transition in terms of who they are as human beings. So it is totally predictable that resistance is part and parcel of organizational change.

The bottom line for the vast majority of people is that change means disengaging from the past and buying into a state of ambiguity and uncertainty. Most will try to hold on to the past, because it is known, safe, and in some cases, important to a sense of self. The bulk of people in organizations impacted by massive change are still enchanted with the ways things used to be.

While management is focused on the future state, they mourn the loss of work environments and personal relationships, which they value.

Eventually, those people who choose to stay with an organization must internalize the new vision, strategy, structure, and processes. They come to realize that there's no turning back. But most individuals only reach this stage through a very demanding and stressful transition process. On any given day during this process, they may come to work having accepted the change and able to look forward toward a future they realize has become the new reality. The next day, their reaction might be entirely different, and they may look back nostalgically at the past. It is not unusual for people to vacillate from one extreme to another, and some may even demonstrate quite emotional, sometimes even dysfunctional behaviour.

### **Resistance comes in many forms**

Being able to lead organizational transformation implies more than looking at the compelling reasons and triggers for change, or even at the vision you want people to aspire to. Leaders must attend to the inevitable consequences, both in terms of helping people give up the past, and in helping them get through the transition period, where emotional disequilibrium is paramount.

So don't be surprised if you encounter resistance, by way of:

- **Confusion.** People who are really bright suddenly don't "get it". They don't seem to understand what's going on, and keep asking for explanations.
- **Criticism.** In a sense, this is a relatively productive form of resistance, because it enables you to address the issues directly.
- **Denial.** People don't believe that the change will really happen.
- **Malicious compliance.** People decide to "show you" by barely going along with the situation; they'll work to rule.
- **Sabotage.** Things seem to disappear, or software you're depending on does not seem to work.
- **Avoidance.** You can't seem to stay on track with the issues at meetings about change. The discussion always seems to be deflected to something else: people really don't want to talk about the change initiative.

- **Silence.** I once wrote an article on 19 things that silence could mean, only one of which is "I agree with you". Oftentimes, the person who is silent is deliberately withholding vital information, and awaiting your unavoidable mistake. You want to hear from these individuals -- and address their concerns -- *before* they give you enough rope to hang yourself.
- **Immediate agreement.** Watch for people who quickly go along with major change initiatives. They often realize later that their initial position was too hasty.
- **Departure.** People choose to leave.

### How not to react to resistance within your organization

Too often, change leaders react in ways that strengthen resistance within their organizations, rather than diffuse it. Try to avoid:

- Using power: overwhelming people by driving changes through.
- Dishonesty: manipulating information or the truth with the view that 'I'll never be found out'.
- An overdose of logic: a textbook explanation on why change is really in the best interest of everyone. People have both rational and emotional responses to change. If you only address the rational side, you'll never reach those people who are reacting on an emotional level, which is also legitimate.
- Playing off relationships: trying to get people to be loyal to you as change is initiated because "we've always helped each other out before".
- Making deals: "if you do this for me, I'll do that for you".
- Killing the messenger who resists: punishing those who bring the information. Instead, try to listen and respond to the messages.
- Acquiescing: giving up too early, before you fully explore what the resistance is all about
- Trying to induce guilt: telling people that they need to go along with change to demonstrate their commitment to good team play. At best, this will result in unwilling acquiescence.
- Ignoring the situation: you must address resistance in order to avoid it going underground and then surfacing as rumours, sabotage or other counterproductive behaviour.

Leaders who engage in some or all of the above "default positions" risk more than just increasing resistance. They risk creating an atmosphere of fear, suspicion and mistrust. Worst of

all, they fail to create synergy within their organizations. And the fact of the matter is, if you're going to successfully implement change, you need teamwork at all levels.

## **Key Actions to Engage In When Confronted By Resistance**

Here are the key actions effective change leaders can engage in when confronted by resistance:

- **Take resistance seriously. Resistance is information for the system.** It gives you another perspective to look at your organization's initiatives. Perhaps you haven't got all the Ts crossed and the Is dotted. Maybe the resisters have additional information that you never considered. Give people permission to express what concerns them.
- **Treat individuals who resist with respect, even those you find hard to fathom.** Chances are, they're not only speaking for themselves, but for a host of others as well. Even if their behaviour makes you uncomfortable, they could be providing you with messages that are worth your attention.
- **Communicate!** Provide employees with information 100 times more often than you deem necessary, and in 10 different ways. The vision and message must be repeated over and over again, as often as it takes. And keep it simple.
- **Take the long view.** You may have to give a little in the short run to achieve victory in the long run.
- **Keep three critical questions foremost in your mind as you go through the change initiative:**

What's in it for me?

What's in it for the people in my organization?

What's in it for us as an organization?

The answers change leaders provide to these questions will ultimately help everyone face change challenges much more successfully.

## **Leading Organizational Change: What Worked And What Didn't**

### **The Queen Elizabeth II Health Science Centre, in Halifax, Nova Scotia**

*These views reflect the experience of Neil Roberts, its president and CEO. Mr. Roberts was the president and CEO of the Halifax Infirmary when it merged with the Camp Hill Medical Centre in 1988. Seven years later, in 1994, the Camp Hill Medical Centre, the Cancer Treatment and Research Foundation, the Nova Scotia Rehabilitation Centre and Victoria General Hospital all merged to become the Queen Elizabeth II Health Sciences Centre, and he became its President and CEO in January 1995. The organization he headed for almost two years is the largest employer in Nova Scotia, with a budget of \$320 million and 6,500 fulltime employees. Its budget was cut by roughly \$24 million over a three-year period.*

#### **What worked**

- We started off by developing a Mission Possible document, which laid out all the issues that we had to deal with, a blueprint for where we were going, and how we were going to get there. More recently, we produced Mission Possible II, which highlighted our progress to date, identified where we failed, celebrated our successes, and showed us where we were heading.
- We asked ourselves whether we would respond to events or take responsibility for generating events. And we chose to take the latter road.
- We thought provincially, not regionally or institutionally.
- We hired a director of public affairs and communication from the private sector to handle our major internal and external communications issues. We provided information lines in every one of our offices, and also had town hall meetings and merger memos.
- We decided that we would generate revenue as well as manage costs. But we also established a set of principals that said the quality would remain, access would not be restricted, and we would find new partnerships where necessary to find the \$24 million. We instilled a business sense among our directors in terms of values versus volumes.
- We involved as many of our employees as possible in the process of functional planning, including developing a clinical model and principals of bringing services to the patients, and grouping services into programs.

- When necessary, we went outside for help. D&T provided us with assistance in benchmarking, and helped us determine the potential savings of our business plan as well as what we would need to invest in information technology. We also got professional help to ensure that we hired good people
- We made hard choices in terms of directors, managers and supervisors.
- We committed to technology as a major enabler of change.
- We convinced the board and government that partnering with the private sector was absolutely necessary, and then invited expressions of interest in clinical reengineering as well as information technology.
- We decided we would have to take on a major debt as an institution.
- We worked with the department of health to develop a labour adjustment strategy to soften what we knew would be inevitable job losses.
- We did an employee and physician satisfaction survey, and announced the results to everyone.
- We maintained a sense of humour.

### **What didn't work**

- We should have placed more emphasis on change management and introduced it in an effective way.
- We did not put sufficient emphasis on **why** we were changing. We did try hard to communicate **how** we were changing, but what evaded us -- and still evades us -- is how to communicate with people when you really have nothing new to tell them.
- We were too slow in getting out the details of the business plan. We should have made it widely available, especially to the unions, who feared we were hiding information from them.
- We were so busy changing things, we didn't celebrate our successes frequently enough. We should have added up the scorecard and done a balance sheet on ourselves more.
- We should have been able to reward people in more than words. Unfortunately, legislation in Nova Scotia prevents us from changing any compensation plans until November 1, 1997. It's not ideal to tell a group of employees to think differently and act differently, then respond to their actions exactly the same way.

## **Capital Health Authority, Edmonton, Alberta**

*These views reflect the experience of Brian Lemon, the first president of Edmonton's Capital Health Authority after Alberta set out to develop regionally integrated health systems. Brian played a key role in implementing the Authority's business plan. The financial targets were extremely aggressive: total expenditures for non-capital items of \$982 million in 1992/93 had to be reduced by about 16%, to \$814 million, for 1995/96. Because \$36 million was reinvested in community services, hospitals had to cut \$200 million -- about 25% of their budgets over a three-year period. Most of the restructuring changes were implemented between April and September 1995. Here are some of the results:*

- *Hospitals realized most of their savings by reducing beds: the region now has 1,650 beds, about half the number it had in 1992/93. There were also reductions in acute separations (reduced to about 70 per thousand from 91 per thousand in 1993/94); a reduction in the number of patients in hospital waiting for placement in continuing care, from 10% down to only 1.3%, and a dramatic increase in day surgery, from 50% two years ago to 68% now.*
- *A close eye by the Boards on waiting lists in cardiovascular surgery, MRIs, admissions to continuing care and joint replacement surgery revealed that in virtually in every area, overall service volumes remained up despite dramatically decreasing dollars. The waiting list for cardiovascular and joint replacement surgery are too long, and MRIs are extremely high; they have started to address these concerns.*
- *The published quarterly results of patient surveys indicate that people who use the system have a high satisfaction rate. A comprehensive staff survey revealed that morale was higher than expected -- though 70% of staff said they did not believe they would have a secure job in the future if they did a good job today.*
- *Ongoing measures of regional re-admission, complication and infection rates demonstrate that overall, these have remained stable, though there have been problems in nursing units, ORs and ICUs which had a lot of bumping or change in medical staff.*

## **What worked**

- **Rapid downsizing.** Our staff satisfaction survey was much higher for those units and hospitals where the reductions were the greatest and done the fastest. Drawn-out downsizing creates uncertainty and dissatisfaction.
- **The broad discussion and consultation process.** Frequently, we asked 150 or 200 people at one of our meetings to help us design the organization and the necessary changes, which resulted in a fair bit of commitment during the implementation process. If anything, I think we should have done even more of that, and included everyone who wanted to participate.
- **The restructuring of governance.** The decisions that were possible because we had public health, home care and continuing care under the same roof as acute care were very powerful. They helped us manage significant reductions in acute care, and substantially enhance community services.

### **What didn't work**

- Restructuring and downsizing at the same time. We had to change the way acute care services were delivered far too quickly. We made major changes to a huge number of service areas, such as support services, lab structures, materials management, food services, and more. At the same time, we downsized management, from 1000 down to 570 managers, many of whose jobs were fundamentally changed.. It was very difficult for people to comprehend and keep up to speed with what was happening. And in many cases, staff didn't know their manager, which created a disconnection between management and staff. Ideally, you should restructure first, then downsize.
- We did not spend enough time communicating. We certainly tried, but peoples' need for communication goes up exponentially during a major change period.
- We frequently lacked sufficient information to make the best possible decisions. We often felt as though we were flying blind.